

### Nutrition Pre-Appointment Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F

How did you hear about our services?  MD Referral  Zoc Doc  MCH Display  Other: \_\_\_\_\_

Have you ever seen a dietitian in the past?  Yes  No If so, when? \_\_\_\_\_

What is your primary reason for meeting with a dietitian? \_\_\_\_\_

What are your long-term health goals? \_\_\_\_\_

#### Eating Attitudes

Do any of these apply to you? (Please check all that apply)

- Eating large portions
- Eating too much sugar
- Eating too many fatty foods
- Consume too much salt
- Eat too fast/not mindfully
- Eat a lot of junk food
- Skipping meals often
- No exercise
- Don't drink enough water
- Eat when not really hungry
- Eat lots of fast food
- Eat little/no fruit/vegetables
- Use a sugar substitute
- Consume juice, sweet tea, or soda
- Drink diet beverages
- Consume caffeinated drinks
- Use frozen meals
- Food allergies or food aversions

Do you believe you are over or undereating?  Yes  No

If so, what situations or emotions trigger these habits? \_\_\_\_\_

Do you have any cravings?  Yes  No For what? \_\_\_\_\_

If so, when do you experience these cravings? \_\_\_\_\_

Do you feel you have a positive body image?  Yes  No

Please complete the sentence, "For me, an ideal meal would be..." \_\_\_\_\_

#### Lifestyle Information

Do you have safe access to exercise? (i.e. walking trail, gym, home equipment) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you engage in physical activity on a regular basis? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please complete the table below</i>		
<b>Activity</b>	<b>Number of Days per Week</b>	<b>Duration (minutes) per Session</b>
Do you have any barriers preventing you from regular exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please explain: _____		

How many hours do you sleep on weekdays?  < 6  6-8  8-10  10+

How many hours do you sleep on weekends?  < 6  6-8  8-10  10+

For Diabetic Patients

Do you check your blood sugars at home?  Yes  No If so, how often? \_\_\_\_\_

What do your blood sugars normally average? \_\_\_\_\_

What was your last a1c number and date measured? \_\_\_\_\_

**Nutrition History**

Have you ever changed your eating habits for a health reason? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please describe.</i>			
Are you currently following a particular diet or nutrition plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please describe.</i>			
Do you avoid any particular foods? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please explain.</i>			
Do you have any adverse food reactions (intolerances or allergies)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please explain.</i>			
<b>Height:</b>	<b>Weight:</b>	<b>Usual weight range:</b>	<b>Desired Weight:</b>
Have you recently lost or gained weight? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe.</i>			
Do you have or have you had an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please describe.</i>			
How many meals do you eat each day?		How many snacks?	
Who primarily does the shopping/cooking in your household?			
Do you ever read the food labels? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what do you look for?			
How many meals do you eat outside the home per week? <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> >6			
If consumed outside the home, where do your meals come from? ( <i>check all that apply</i> )			
<input type="checkbox"/> restaurant <input type="checkbox"/> fast food <input type="checkbox"/> take out <input type="checkbox"/> ready-made meals <input type="checkbox"/> meal delivery service <input type="checkbox"/> other _____			
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how many drinks per week?			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you drink caffeinated beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how many cups per day?			
Do you use any artificial sweeteners? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which ones?			
What is your favorite meal?			

Are you currently taking any vitamins or minerals?  Yes  No *If yes, please list them below.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initials \_\_\_\_\_

For office use only

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_



# Client Health Check Questionnaire

Please check the box for any health condition that applies to you:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies (list: _____)                      | <input type="checkbox"/> Cystitis or urinary track infection        | <input type="checkbox"/> Menopausal symptoms                               |
| <input type="checkbox"/> Allergic rhinitis and hay fever              | <input type="checkbox"/> Excess body fat and obesity                | <input type="checkbox"/> Muscle cramping and aches                         |
| <input type="checkbox"/> ASDV (arteriosclerotic vascular disease)     | <input type="checkbox"/> Excess alcohol and hangovers               | <input type="checkbox"/> Otitis and ear infections                         |
| <input type="checkbox"/> Blood disorders and anaemia                  | <input type="checkbox"/> Exhaustion and chronic fatigue             | <input type="checkbox"/> Varicose veins                                    |
| <input type="checkbox"/> Cancer, lumps, tumour                        | <input type="checkbox"/> Enteritis or Crohn's syndrome              | <input type="checkbox"/> Podagra, gout, elevated uric acid                 |
| <input type="checkbox"/> Chest tightness, shortness of breath, asthma | <input type="checkbox"/> Hypertension or high blood pressure        | <input type="checkbox"/> Pregnant or lactating                             |
| <input type="checkbox"/> Cold sores and herpes labialis               | <input type="checkbox"/> Hypo- or hyper-thyroidism                  | <input type="checkbox"/> Stomach pain, heartburn, or indigestion           |
| <input type="checkbox"/> Common colds, viral infections, and flu      | <input type="checkbox"/> Insomnia and sleeping disorders            | <input type="checkbox"/> Sinus inflammation (sinusitis)                    |
| <input type="checkbox"/> Contusions, bruises, burns, and cuts         | <input type="checkbox"/> IBS (irritable bowel syndrome)             | <input type="checkbox"/> Slow colonic transit or constipation              |
| <input type="checkbox"/> Colon inflammation and colitis               | <input type="checkbox"/> Insulin resistance or diabetes             | <input type="checkbox"/> Stomach ulcers                                    |
| <input type="checkbox"/> Chronic pain and fibromyalgia                | <input type="checkbox"/> Joint problems, arthritis, or osteoporosis | <input type="checkbox"/> Thrush, fungal infections, or candida             |
| <input type="checkbox"/> Calculi and gallstones                       | <input type="checkbox"/> Lung infection or bronchitis               | <input type="checkbox"/> Taking medication (list): _____                   |
| <input type="checkbox"/> Dementia and Alzheimer's                     | <input type="checkbox"/> Low immunity or recurrent infections       | _____  |
| <input type="checkbox"/> Diverticula inflammation (diverticulitis)    | <input type="checkbox"/> Mood disorders or depression               | <input type="checkbox"/> Other health conditions or symptoms (list): _____ |
| <input type="checkbox"/> Dermatitis, psoriasis, or skin conditions    | <input type="checkbox"/> Migraines or headaches                     | _____  |
|   | <input type="checkbox"/> Recent accident or major operation         | _____  |

# Medical Referral Form

**If you have "checked" one or more boxes in the Client Health Check Questionnaire:**

Talk to your doctor or GP by phone or in person *before* you embark on a new nutritional programme. Tell your doctor about this questionnaire and which health conditions you have checked. You may be able to undertake a new nutritional programme – as long as you do it with your doctor's opinion. Talk with your doctor or GP about the kind of nutritional programme you wish to embark on and follow his/her advice.

**Please note:** If your health changes so that subsequently you answer "yes" to any of the health check conditions, inform your health professional or Nutritional Therapist immediately. Talk with your doctor or GP about the kind of nutritional programme that you are on, and follow his/her advice.

- I have read, understood, and completed the Client Health Check Questionnaire
- All questions have been answered to the best of my knowledge
- I am happy to participate in a nutritional therapy programme

Name: \_\_\_\_\_ Date: \_\_ / \_\_ / \_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

## INFORMED CONSENT FORM – NUTRITIONAL THERAPY PROGRAMME

I acknowledge that the purpose of this programme is to help me improve my health, wellness, and lifestyle.

I am employing the services of [ ] so that I can obtain information and guidance about health factors within my own control (such as diet, hydration, lifestyle, wellness, and various other related behaviours) in order to help support my health and wellness.

I understand that he/she is a nutritional educator and does *not* dispense medical advice nor prescribe treatment. Rather, he/she provides education to enhance my knowledge of health as it relates to food consumption, hydration, lifestyle, and related activities. While nutritional support can be an important complement to my medical care, I understand that a nutritional therapy programme is *not* a substitute for the diagnosis, treatment, or care of a disease, illness, or injury by a medical provider.

Nutritional evaluations and lifestyle assessments are not intended for the diagnoses of disease. Rather, these are intended as a guide for the development of a nutritional programme and used to monitor my progress in achieving my health and wellness goals.

I understand that [ ] will keep all documents related to me (including, but not limited to, assessments, food diaries, forms, worksheets, audio, transcripts, video, or images) and any notes that relate to me, as a record of our work together. I understand that records may also document the topics that we talk about, my progress, plans discussed, or any other considerations that may be helpful to my health and wellness. Records will be stored in a secure location.

Medical records, personal information and health history divulged to [ ], in or out of session, will be **kept strictly confidential** unless I consent to sharing this information by way of a signed release.

I understand that every person is unique and it is not possible to determine in advance how my system will react to certain foods, drinks, supplements, or dietary products that may be suggested to me from time to time. I agree that it may be necessary to adjust my plan from time to time or until my body can begin to properly accept nutritional changes. I accept that it is my responsibility and decision to use or disregard nutritional, exercise, and lifestyle guidelines. It is also my responsibility to hydrate well, get plenty of rest, and learn about nutrition.

I agree to hold [ ] harmless for claims or damages in connection with our work together under the terms of this consent form. I understand that this consent form is also a release of his/her liability. I accept that the advice under this programme is not a guarantee for health improvements or for reaching my health goals, and that I should not use food products or supplements as a substitute for medical treatment or a varied diet.

All components of the programme have been explained to me and demonstrated but I should feel free to ask any questions I may have. I agree that I will inform [ ] if there is any reason why I should not continue with the programme; for example, an illness or an injury that require medical advice. If, at any time, I feel undue pain or excessive discomfort, I will **stop the programme undertakings immediately** and inform [ ] of my symptoms. I am at all times responsible for seeking medical advice where appropriate.

I understand I am free to **withdraw from the programme at any time I wish**. I agree to take part in the programme described to me by [ ]. The nature, purpose, risks, and benefits have been explained to me and I understand what is required of me and that I may withdraw at any time. The services may also be terminated at the discretion of [ ] with sufficient notice.

I understand the intellectual property rights and privacy of all of the materials and information provided to me during this programme. I agree to use the session handouts, worksheets, and questionnaires for my own personal (non-commercial) purposes only and that I will not share, copy, or distribute them to third parties.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_